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ABSTRACT

While current research is beginning to suggest that it is masculinity that correlates with mental health, results are inconclusive and studies have primarily focused on limited measures of mental health. This study incorporated multiple measures of self-concept in an analysis of the relationship between sex-role orientation and mental health of women. Subjects (N=293) were female professionals, graduate students, mental health clients, and victims of domestic violence from five regions of the United States. Subjects completed four subscales from the Personal Orientation Inventory, the Tennessee Self-Concept Scale, Rosenberg's self-esteem scale, Rotter's Internal-External Locus of Control Scale, the Bem Sex Role Inventory, and a demographic data sheet. The results indicated a strong, positive correlation between masculinity and all six measures of self-concept as well as internal locus of control. Results suggest that females high in masculinity (and subsequently either a masculine or androgynous sex role orientation) are more likely to have a better self-concept, including more inner-directed support, self-regard, self-acceptance, and self-esteem; more internal locus of control; a higher level of education; and a more professional occupation than their feminine and undifferentiated counterparts who reflect low masculinity. (NB)

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Gender-Role Conditioning and Women's Self-Concept

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Gender-Role Conditioning and Women's Self-Concept

Abstract

This study supports the accumulative body of literature which is suggesting that masculinity is a strong predictor of mental health in women. Masculine and androgynous sex-role orientations, both of which incorporate high masculinity scores, were strongly related to positive self-concept, while feminine and undifferentiated orientations, which incorporate low masculinity scores, were associated with poorer self-concept.

Gender-Role Conditioning and Women's Self-Concept

The acquisition of appropriate sex-typed behaviors and characteristics, resulting in a masculine identity in males and a feminine identity in females was historically considered a prerequisite to mental health by theorists of socialization processes (Bandura, 1969; Kagen, 1964; Kohlberg, 1966; Mischel, 1966; Mussen, 1969). This sex-typing process was traditionally based upon the assumption that masculinity and femininity were mutually exclusive personality dimensions that were bipolar in nature. Masculinity has been considered instrumental and competency-oriented, including such traits as independence, objectivity, rationality and competitiveness; while femininity has been viewed as expressive and relationship-oriented, with traits such as dependence, intuition, emotionality and submissiveness (Heilbrun, 1973; Kohlberg, 1966; Singer, 1976). Not only has the learning of such sex-typed behaviors historically been considered essential to the socialization process, but the learning of appropriate sex-role behaviors has been considered one of the most salient lessons in society (Kaplan, 1976; Kohlberg, 1966; Mischel, 1966).

While differential behaviors and characteristics have been endorsed in the sex-typing process, the more competency-oriented masculine traits have been consistently viewed as more positive and more valued than feminine traits by society (Bassoff & Glass, 1979;

Broverman, Vogel, Broverman, Clarkson, Rosenkrantz, 1972; Deaux, 1984; Taynor & Deaux, 1973, 1975), including society's mental health professionals (Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970). The literature, at the same time, clearly suggests that women struggle with self-concept related issues which appear to be related to self-devaluation. Women have been shown, for example, to discredit their own abilities (Clance, 1978), have lower expectancies of their abilities (Deaux, 1976; Karabenick, Sweeney, Penrose, 1983; Skrypnke, & Synder, 1983) and attribute their success to factors other than their own competency (Frieze, Whitley, Hanusa & McHugh, 1982; Nicholls, 1975). Studies have not only revealed that females may experience a fear of success (Horner, 1970; Savage & Stearns, 1979), but have indicated that the fear is related to the belief that success is incompatible with femininity and their female sex-role (Horner, 1970; Sohn, 1982). The literature has further indicated that such issues as passivity and accommodating behaviors (Frieze, et al., 1982; Froming, 1978; Tolor, Kelly & Stebbens, 1976), fear of taking a stand and mistrust of one's own judgement (Deaux, 1984), are frequently demonstrated as obstacles for women. Highly sex-typed behavior in women has additionally been correlated with anxiety, low self-esteem and poorer emotional adjustment (Bem, 1975, Deaux, 1984; Kaplan, 1976).

The dilemma for women is apparent. The sex-role socialization process validates characteristics in the feminine sex-role such as dependency, unassertiveness, and discrediting one's own abilities -- characteristics which may well interfere with actualizing their individual potential and the development of a positive self-concept.

It has, indeed, been pointed out that the female sex-role stereotype in our society is not compatible with what mental health professionals consider to be a healthy, mature adult (Bem, 1974; Heilbrun, 1973; Pyke, 1985), so that a mature adult female with the characteristics of the feminine sex-role would not be considered to be a psychologically healthy adult (Broverman, et. Al., 1970).

In recent years concern regarding the restrictive effect that traditional gender role conditioning can have on mental health has become widespread. Masculinity and femininity are no longer viewed as mutually exclusive dimensions of a bi-polar continuum, and the concept of psychological androgyny--the endorsing of both traditionally masculine and feminine attributes--has reorganized traditional perspectives on sex-roles (Bem, 1974; Heilbrun, 1973; Singer, 1976). The concept generated widespread research on androgynous versus sex-typed individuals (Adams & Sherer, 1982; Bem, 1974; Bem, Martyna & Watson, 1976; Deaux, 1984; Orlofsky & O'Heron, 1987; Pyke, 1985; Spence, Helmreich & Stapp, 1975) with the expectation that androgynous individuals would reflect greater general adjustment and mental health than their sex-typed counterparts.

The current empirical research attempting to associate sex-role orientation with mental health has so far increasingly and consistently suggested however, that it is the society-valued competency-oriented masculine attributes that correlate with high self-esteem in both males and females (Adams & Sherer, 1982, Bassoff & Glass, 1979; Cooke, 1985; Deaux 1984; Long, 1986; Long, 1989; Orlofsky, & O'Heron, 1987; Pyke, 1985; Taylor & Hall, 1982; Whitley, 1983). Results are indicating that while androgyny is also associated with mental health in women, it

appears to be the masculine dimension of androgyny that is the predictor (Antill & Cunningham, 1980; Bassoff & Glass, 1979; Deaux, 1984; Taylor & Hall, 1982). Femininity, on the other hand, appears to be either irrelevant or slightly negative when correlated with self-esteem (Antill & Cunningham, 1979; Bassoff & Glass, 1979; Moore & Rosenthal, 1980; Orlofsky, & O'Heron 1987), while undifferentiated individuals appear to have the least self-esteem (Adams & Sherer, 1982; Bem, 1977, Cooke, 1985; Deaux, 1984; Orlofsky & O'Heron, 1987; Spence, et. Al., 1975; Whitley, 1983).

While the research is suggesting that it is masculinity that correlates with mental health, rather than androgyny or femininity, studies have focused on limited measures of mental health, primarily self-esteem. The present study incorporated multiple measures of self-concept, including time competency, inner-directed support, self-regard, self-acceptance, and self-esteem as well as locus of control, in its analysis of the relationship between sex-role orientation and mental health of women.

METHOD

Subjects

Subjects for the study were 293 adult women (18 years and older) They represent four categories of volunteers: professional women (employed in an occupation with a recognized professional association requiring at least a college degree), university graduate students, clients (outpatients from mental health agencies or private practice,

excluding psychotics or mentally impaired) and victims of domestic violence (who reside or have resided within the past year at a shelter). Of the 293 subjects in the study there were 95 professionals, 86 students, 54 clients and 58 victims of domestic violence. All subjects were volunteers responding to either verbal or written announcements regarding voluntary participation in the study.

Instruments

Three instruments provided six measures of self-concept. Four subscales were used from the Personal Orientation Inventory (POI), including:

(a) Time Competency--the ability to live in the present

(b) Inner-directed support--using internal judgement criteria,

(c) Self-Regard--a measure of recognition of strengths and

(d) Self-Acceptance--acceptance of one's weaknesses, (Shostrom, 1974).

The total score from the Tennessee Self-Concept Scale (TSCS) provided a fifth measure of self-concept, (Fitts, 1964), and Rosenberg's self-esteem scale (Rosenberg, 1979) provided the sixth measure. Two other instruments were administered for purposes of correlation with the self-concept measures: Rotter's Internal-External Locus of Control Scale, (Rotter, 1966), used to measure an individual's perception of his/her control over life experiences, and Bem's Sex-Role Inventory (BSRI), used to determine a person's sex-role orientation (Bem, 1974). The BSRI identified each subject as masculine, feminine, androgynous, or undifferentiated based upon the subject's relative rating of 60 adjectives.

Procedure

Subjects in the study were asked to complete the five instruments used as well as a Demographic Data Sheet. A computation of z scores was then done on each of the six measures of self-concept followed by a composite mean z score computed for each subject. Subjects were then divided into four levels of self-concept, based upon a rank ordering of mean z scores:

High - consisting of those subjects with mean z scores that fall in the top 10% (n = 30)

High Middle - consisting of those subjects with mean z scores below the top 10% but above the mean (n = 116)

Low Middle - those subjects with mean z scores below the mean but above the bottom 10% (n = 117)

Low - subjects whose mean z scores fall in the bottom 10% (n = 30).

Each subject's sex-role orientation was classified as androgynous, masculine, feminine or undifferentiated according to relative scores of masculinity and femininity on Bem's Sex Role Inventory. Data analysis included a one way analysis of variance performed on the levels of self-concept with mean z scores, locus of control scales, masculinity and femininity scores as dependent variables. Tukey's method for comparisons (p = < .05) was used to determine significance of difference between levels.

A Pearson product-moment correlation was performed on mean z scores, locus of control, masculinity and femininity scores, as well as

on the six scales used to measure self-concept: Time Competency, Inner-directed Support, Self-Regard, Self-Acceptance, TSCS score and Rosenberg's Self-Esteem Scale.

A cross-tabulation and chi-square analysis of frequencies using a two-tailed test were done both on levels of self-concept by subject source, sex-role orientation and demographic data, and on sex-role orientation by subject source and demographic data.

RESULTS

A one-way analysis of variance was performed on the four levels of self-concept. Dependent variables included mean z scores, Rotter's Locus of Control scores, and masculinity and femininity scores. The difference in mean z scores between levels of self-concept was very significant ($F = 518.5$, $p = < .001$), and Tukey's method for comparisons ($p = < .05$) revealed that each of the four levels of self-concept differed significantly from each of the other three, reflecting a broad range in self-concept of the 293 subjects.

A Pearson product-moment correlation was also performed, and demonstrated a correlation between the masculinity score and self-concept mean z score ($r = .418$, $n = 293$, $p = < .001$), as well as between the masculinity score and all six measures of self-concept: time competency ($r = .24$, $n = 293$, $p = < .001$), self-regard ($r = .43$, $n = 293$, $p = < .001$), self-acceptance ($r = .20$, $n = 293$, $p = < .001$), TSCS ($r = .33$, $n = 293$, $p = < .001$) and RSES ($r = .37$, $n = 293$, $p = < .001$). A negative correlation was found between the masculinity score and locus of control ($r = -.21$, $n = 293$, $p < .001$) reflecting a

correlation with internal locus of control.

Correlations with the femininity score reflected a lower correlation between the mean z score and femininity score (r = .119, n = 293, p = < .05), a correlation with time competency (r = .24, n = 293, p = .01), TSCS (r = .11, n = 293, p = < .025) RSES (r = .12, n = 293, p = <.02), no correlation between the femininity score and inner-directed support, self-regard, self-acceptance, and no correlation between the femininity score and locus of control.

A chi-square analysis of frequencies using tests for goodness of fit was performed on the levels of self-concept. Results indicated a significant difference between levels of self-concept (See Table 1), and sex-role orientation (x = 30.91, df = 9, n = 293, p = < .001); and between levels of self-concept (See Table 2), and subject source (x = 45.79, df = 9, n = 293, p < .001). Results indicated no significant differences between levels of self-concept and marital status, ethnicity, age, religion, income or ordinal position.

A chi-square analysis of frequencies was also performed on sex-role orientation. Results indicated a significant difference between sex-role orientation (See Table 3), and subject source (x = 52.41, df = 9, n = 293, p = < .001). No significant differences were demonstrated between sex-role orientation and marital status, ethnicity, age, income, or ordinal position.

DISCUSSION

Results of this study support the recent contention that masculinity, rather than androgyny or femininity, has a strong positive

relationship with mental health. Present findings suggest that it is masculinity that is the greater predictor of positive self-concept in females. Results indicate a strong, positive correlation between masculinity and all six measures of self-concept as well as internal locus of control. The significant difference in masculinity scores between self-concept levels suggests that it is a solid discriminator.

Femininity scores, on the other hand, appear to be largely irrelevant as predictors of self-concept. Results indicate a nominal correlation between only three measures of self-concept, and no correlation with inner-directed support, self-regard, self-acceptance or locus of control.

Sex-role orientation appears to be strongly related to self-concept, with results of this study supporting past findings which suggest that both androgynous and masculine orientations correlate with mental health, while feminine and undifferentiated orientations do not. As indicated in Table 1, the high self-concept level is comprised of 80% androgynous (n=13) and masculine (n=11) sex-role orientations, (with only 3 feminine and 3 undifferentiated), while the low level is comprised of 76.6% feminine (n=11) and undifferentiated (n=12), (with only 2 androgynous and 5 masculine). Further, there appears to be a direct relationship between androgynous or masculine sex-role orientations and high self-concept, with the combined categories making up 80% of the high level, 58. [illegible]f the high middle. Conversely, there appears to be a direct relati[illegible]nip between feminine or undifferentiated sex-role orientations and low self-concept, with these combined categories making up 76.6% of the low level self-concept, and 60.6% of the low middle. Based upon these data females with androgynous

and masculine sex-role orientations can likely be expected to have higher self-concepts, while females with feminine and undifferentiated sex-role orientations can likely be expected to have poorer self-concepts.

Results also indicate a strong correlation between positive self-concept and both higher education and more professional occupations (See Table 2). A chi-square value of 45.8 indicated a significant difference in numbers of professional, student, client and battered females in the four levels of self-concept ($p = < .001$), and as indicated in Table 2, the difference is reflected in the professional and student categories compared with the client and battered categories. While professionals and students comprise 80% of the high self-concept category, clients and battered women comprise 83.3% of the low self-concept category.

Finally, the study also found a strong relationship between sex-role orientation and subject source. (See Table 3). A chi-square value of 52.4 indicated a significant difference in frequencies of numbers of professional, student, client and battered women who had androgynous, masculine, feminine or undifferentiated sex-role orientations ($p = < .001$). As Table 3 indicates, 66% of the professional women had a sex-role orientation of androgynous or masculine, 61% of women students were androgynous or masculine, while 81.4% of female clients had a feminine or undifferentiated sex-role orientation, and 67.2% of battered women were feminine or undifferentiated.

Implications of these findings for facilitators of mental health are significant. While females in our society continue to be

conditioned, to develop feminine attributes, research findings are suggesting that the masculine attributes are what relate to self-esteem and mental health. The problem for women becomes obvious: women are conditioned to develop feminine characteristics which are opposite of the masculine characteristics found to predict a positive self-concept. Thus, women, when conditioned with only the traditional feminine attributes, are actually conditioned to develop a poor self-concept.

Counselors and educators need to recognize this challenging dilemma for women if they are to help facilitate their mental health. An obvious solution involves helping women to develop the masculine attributes (i.e. assertive, willing to take a risk, leadership potential, independent, rational) which are shown to predict positive self-concept. Given their previous conditioning, however, it often involves first unlearning and then re-learning attitudes and behaviors. The following steps might be considered in helping women develop a more positive self-concept:

1) facilitating an awareness and understanding of the gender-role conditioning process,
2) facilitating an understanding of the specific influences and effects of the gender-role conditioning process on them individually,
3) identification of the masculine traits which the female client would like to strengthen, and
4) facilitation of a strategy for development and strengthening of identified traits and behaviors.

Throughout this process the female client and student need continued

support and empowerment. The reminder that her original conditioning was environmental and that she responded to it with normal reactions and behavior will help prevent guilt feelings for not having developed stronger self-esteem. Additionally, since women are conditioned to defer and accommodate, it is important to make sure that female clients and students are not simply complying with the authority figure in the counseling or educational process. Encourage and support initiative-taking.

In conclusion, although further substantiating research is warranted, it appears that masculinity is the better predictor of female mental health than either androgyny or femininity. The dimension of femininity by itself appears to be largely irrelevant to degree of mental health.

A strong relationship is suggested between sex-role orientation and positive self-concept, with androgynous and masculine females having significantly better self-concepts than feminine or undifferentiated females. More specifically, results suggest that females high in masculinity (and subsequently having either a masculine or androgynous sex-role orientation) are more likely to have a better self-concept, including more inner-directed support, self-regard, self-acceptance, self-esteem, and internal locus of control, than their feminine and undifferentiated counterparts, who reflect low masculinity. Based upon this, and previous research findings, it appears that to facilitate women's positive self-concept means to reinforce the development of the traditional masculine attributes and behaviors .

self-con #4

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Table 1

Chi-Square Analysis of Frequencies: Levels of Self-Concepts by Sex-Role Orientation

Key: n
Row Percent
Column Percent
Total Percent

	Sex-Role Orientation				
	Androgynous	Masculine	Feminine	Undifferentiated	Row Total:
High	13 43.3 17.8 4.4	11 36.7 15.3 3.8	3 10.0 4.3 1.0	3 10.0 3.8 1.0	30 10.2
High Middle	33 28.4 45.2 11.3	35 30.2 48.6 11.9	26 22.4 37.1 8.9	22 19.0 28.2 7.5	116 39.6
Low Middle	25 21.4 34.2 8.5	21 17.9 29.2 7.2	30 25.6 42.9 10.2	41 35.0 52.6 14.0	117 39.9
Low	2 6.7 2.7 0.7	5 16.7 6.9 1.7	11 36.7 15.7 3.8	12 40.0 15.4 4.1	30 10.2
Column Total:	73 24.9	72 24.6	70 23.9	78 26.6	293 100.0

Chi-Square = 30.91, df = 9, n = 293, p = <.001

Table 2

Chi-Square Analysis of Frequencies: Levels of Self-Concept by Subject Source

Key: n
Row Percent
Column Percent
Total Percent

	Subject Source				
	Battered	Clients	Professional	Student	Row Total:
High	3 10.0 5.2 1.0	3 10.0 5.6 1.0	14 46.7 14.7 4.8	10 33.3 11.6 3.4	30 10.2
Middle	13 11.2 22.4 4.4	14 12.1 25.9 4.8	43 37.1 45.3 14.7	46 39.7 53.5 15.7	116 39.6
Low Middle	29 24.8 50.0 9.9	25 21.4 46.3 8.5	35 29.9 36.8 11.9	28 23.9 32.6 9.6	117 39.9
Low	13 43.3 22.4 4.4	12 40.0 22.2 4.1	3 10.0 3.2 1.0	2 6.7 2.3 0.7	30 10.2
Column Total:	58 19.8	54 18.4	95 32.4	86 29.4	293 100.0

Chi-Square = 45.79, df = 9, n = 293, p = <.001

Table 3

Chi-Square Analysis of Frequencies:

Sex-role Orientation by Subject Source

Key: n
Row Percent
Column Percent
Total Percent

	Suject Source				
	Battered	Client	Professional	Student	Row Total:
Androgynous	12 16.4 20.7 4.1	7 9.6 13.0 2.4	25 34.2 26.3 8.5	29 39.7 33.7 9.9	73 24.9
Masculine	7 9.7 12.1 2.4	3 4.2 5.6 1.0	38 52.8 40.0 13.0	24 33.3 27.9 8.2	72 24.6
Feminine	14 20.0 24.1 4.8	22 31.4 40.7 7.5	18 25.7 18.9 6.1	16 22.9 18.6 5.5	70 23.9
Undifferentiated	25 32.1 43.1 8.5	22 28.2 40.7 7.5	14 17.9 14.7 4.8	17 21.8 19.8 5.8	78 26.6
	58 19.8	54 18.4	95 32.4	86 29.4	293 100.0

Chi-Square = 52.41, df = 9, n = 293, p = <.001